



Ensuring Adequate Resources for Patients and Communities

Medicare

Small or Rural Hospitals

Issue

Rural hospitals provide essential health care services to nearly 54 million people, including 9 million Medicare beneficiaries. Yet because of their small size, modest assets and financial reserves, and higher percentage of Medicare patients, they face great pressures as government payments decline. Given that rural populations are typically older, rural hospitals are even more dependent on Medicare. Yet Medicare margins are the lowest for rural hospitals, with the smallest hospitals having the lowest margins.

AHA View

National payment policies, whether for prospective payment or cost-based systems, often fail to recognize the special characteristics and unique circumstances of small rural hospitals. Many rural hospitals are too large to qualify for CAH status but too small to absorb the financial risk associated with PPS programs. CAHs struggle to provide essential services to their rural communities because of low volumes. **As a result, the AHA advocates for the following legislation, which was introduced in Congress earlier this year:**

- ***The Sole Community Hospital Preservation Act*** (H.R. 1177) – Introduced by Reps. Tanner (D-TN) and Graves (R-MO), this bill would extend permanently the outpatient PPS hold harmless and permit the use of a more current year to re-establish the hospital target amount.
- ***The Physician Pathology Services Continuity Act*** (S. 458/H.R. 1105) – This bill, introduced by Sens. Blanche Lincoln (D-AR) and Craig Thomas (R-WY) and Reps. John Tanner (D-TN) and Kenny Hulshof (R-MO), would permanently extend the grandfather clause to allow Medicare to continue to make direct payments to independent laboratories for the technical component of pathology services.
- ***Rural Health Services Preservation Act*** (S.630/H.R.2159) – This bill has been introduced in both the House and Senate by Sens. Coleman (R-MN), Harkin (D-IA) and Durbin (D-IL) and Reps. Kind and McMorris-Rodgers. It would require MA plans to pay CAH and RHC services, at minimum, what they otherwise would have been paid under Medicare (101% of allowable costs) with cost reconciliation, or 103% of interim rates without reconciliation (in or out of network).
- ***Critical Access To Clinical Lab Services Act*** (S. 1277) – Introduced by Sen. Ben Nelson (D-NE) this bill would work to restore cost-based reimbursement of referral lab services



Other Legislative Priorities. The AHA also will work to extend expiring legislative provisions, including a home health 5 percent rural add-on, cost-based payment for rural laboratory services provided by hospitals with less than 50 beds and ambulance mileage bonuses for transport of rural patients in low-population density areas. In addition, the AHA will work to expand existing cost-based payment to home health and skilled nursing facility settings for CAHs and to rural hospitals with 25-50 beds for inpatient and outpatient services; and to allow flexibility for CAH relocation.

340B Drug Discount Program. Safety-net hospitals depend on the 340B drug discount program to provide pharmacy services to some of their most vulnerable patients. Currently, the program is available only for outpatient services provided at disproportionate share hospitals. However, these hospitals, often with poor financial margins, are unable to benefit from the program for the pharmacy services they furnish to inpatients. **Therefore, the AHA will work to make drug prices under the 340B outpatient drug discount program available for inpatient services at 340B hospitals.** We also will seek to expand eligibility to CAHs, sole community hospitals, Medicare-dependent hospitals and rural referral centers, which serve as the rural safety net.

Inpatient PPS. The Centers for Medicare & Medicaid Services' (CMS) proposed inpatient prospective payment system (PPS) rule for FY 2008 would impose drastic cuts on Medicare payments to hospitals. In particular, the agency proposes a 2.4 percent cut to all hospitals in 2008 and 2009 in anticipation of coding changes CMS says hospitals might make under a new severity diagnosis-related group (DRG) system. CMS would create 745 new Medicare-Severity DRGs to replace the current 538 DRGs, and would overhaul the complication or comorbidity list. The reclassification would create up to three tiers of payment for each diagnosis. The rule also proposes eliminating the capital update for urban hospitals and the large urban add-on to capital payments. CMS also is considering discontinuing the teaching and disproportionate share hospital adjustments to capital payments. The rule includes a market basket update of 3.3 percent for those hospitals that submit data on 27 quality measures; hospitals not submitting data would receive a 1.3 percent update.

The AHA is analyzing the rule to understand its full impact; however, we oppose the 2.4 percent "behavioral offset" and cuts to capital payments, which will cut payments to hospitals by over \$25 billion over the next five years. The AHA will work with the hospital field to develop our position and best response to the regulation.

CMS' Interpretative Guidelines on CAHs. CMS State Operations Manual's Interpretive Guidelines have limited CAHs' ability to relocate and build a replacement facility and maintain its critical access status. Specifically, the guidelines alter the definitions of mountainous terrain and secondary roads, and require review after one year as to whether the relocated hospital continues to serve 75 percent of the same population, provide 75 percent of the same services



and employ 75 percent of the same staff. Necessary providers that fail the 75 percent test would lose their CAH status and be forced to convert back to the inpatient PPS, hurting these facilities' ability to continue providing care in their communities. **The AHA will continue to urge CMS to restate the definitions and adopt a five-mile safe harbor for relocating CAHs before applying the 75 percent test.**

Medicare wage index. *The Tax Relief and Health Care Act of 2006* requires MedPAC to recommend possible alternatives to the Medicare area wage index by June 30. CMS must consider these recommendations in its FY 2009 hospital inpatient PPS proposed rule. To consider possible reform of the area wage index, the AHA has convened a workgroup of national, state, regional and metropolitan hospital association executives. We agree that the area wage index is not functioning well and requires change. In particular, the current system is volatile – neighboring counties can have very different indices, and a hospital's wage index can drop even when the hospital increases wages substantially.

The AHA and its workgroup will continue to work with MedPAC and CMS throughout the next two years to develop potential changes that will address some of the existing area wage index's shortcomings.